

THE WORKER'S COMPENSATION STATE NETWORK

Department of Administration

Section 102.08, Wis. Stats. confers responsibility upon the Department of Administration (DOA) for “timely delivery of benefits to employees of the state and their dependents and other functions of the state as an employer...”

The Division of State Agency Services, Bureau of State Risk Management (BSRM) is the agency designated to carry out the Department's management of the program. BSRM also administers the state's self-funded property and liability coverage, safety and loss control, and environmental compliance.

Section 102.08, Wis. Stats. also enables DOA to delegate delivery of benefits to other state agencies. Delegation agreements have been implemented with the Department of Transportation (DOT) and the University of Wisconsin System.

How Coverage is Provided and Financed

The state program is similar to self-insurance by private employers. Worker's compensation benefits are paid directly by the state from general revenue and program revenue sources.

BSRM, DOT, and UW System claims units pay benefits from a central fund account maintained by DOA. DOA's administrative costs include program management, claims adjusting services, vendor-furnished claims services, and an annual assessment paid to the Department of Workforce Development (DWD). DOA assesses premium annually based on benefits and administrative costs for the prior fiscal year.

Assessments are levied against each state agency and the University System. Assessments against the 6 largest agencies (Health & Social Services, Corrections, DOT, UW System, DWD, and Natural Resources) are based on 100% experience. “Experience” means the actual claims costs incurred the previous year.

The remaining smaller agencies are assessed premium on the basis of 50% experience and 50% exposure. “Exposure” means the extent of losses that are estimated for the year based on the degree of accident danger present in the different types of employees working for the agency. For example, agencies with many office clerical workers will have less exposure than agencies with many outdoor construction workers. Those agencies with higher exposure will pay a greater share of the premium allocation than those with less exposure. Another reason for this modification is that smaller agencies cannot absorb the costs of catastrophic injuries as easily as larger agencies. Therefore, a percentage of the costs of such an injury will be shared by all agencies.

Claims Adjusting Services

DOA, DOT and UW System each have claims units providing claims adjustment services. Claims examiners and claims representatives (claims handlers) receive and determine compensability of claims by injured state employees. Claims are received from worker's compensation coordinators employed by each agency or campus. Once the claim is received and a case file is opened, the claims handler gathers additional information, including medical reports and supervisor's statements, and decides whether to approve or deny payment of the claim.

There are several services available to help claims handlers manage their claims:

Managed medical care is a comprehensive strategy which can contain a number of programs designed to make medical treatment more effective and more timely, and provide deliberate cost controls. The managed medical care program includes:

Medical case management, provided by the Division of Vocational Rehabilitation (DVR) in the Madison area and private rehabilitation nursing services for other parts of the state. Nurses are trained to obtain treatment plans and work with the employee, the employer, the claims handler, and the physician to assure quality care and an early return to work (RTW). Case managers are assigned to difficult cases where the medical treatment is complex, the employee is less able or willing to obtain appropriate treatment and RTW, or the employing state agency needs help in facilitating recovery and RTW.

Telephonic Case Management (TCM), was initiated in 2000 to replace "medical utilization review" TCM gives claims examiners greater discretion over which cases need attention and aims reviews at significant medical costs or complicated medical treatment issues and enables selective review of providers who consistently over treat.

Medical bill auditing enables a private audit firm to compare each medical bill against a DILHR-approved fee schedule and reprice the bill if necessary. Other factors in repricing, or reduction of charges are identified by the auditors as well, such as duplicate bills, excessive treatment, and treatment not related to the injury.

A Preferred Provider Organization (PPO), employed to provide generally better service, pre-programmed managed care and a discount to the state for employees treating with providers who are members of the PPO.

Besides managed medical care, other services employed by claims handlers include:

Claims investigation services, obtained from private investigation firms. Investigations are used by claims handlers to obtain recorded statements and background checks on suspicious claim situations, such as an employee who does not fully explain the circumstances of an accident. In some cases, surveillance videos may be obtained to determine whether injured employees are living within the restrictions prescribed by their physicians.

Vocational Rehabilitation Services, provided under a unique “State Injured Employees Reemployment Program.” Since state government is a large and diverse employer, it is often possible to find alternate employment for the more severely disabled employees with the current agency or another agency. The Reemployment Specialist can expedite placement or, if needed, enroll the employee in a vocational rehabilitation program. Private vendors provide vocational experts to conduct **Loss of Earning Capacity evaluations** (LOEC). A LOEC evaluation is needed when the injured employee cannot return to employment at a wage of at least 85% of the wage earned at the time of injury. The LOEC evaluation establishes the degree of the employee’s wage loss.

Other Administrative Services

DOA works cooperatively with DOT and UW System to develop the administrative and claims management structure necessary to competently administer the state worker’s compensation program. Some of the DOA administrative duties include preparing accident analysis and reporting forms and procedures, establishing case reserve guidelines, issuing requests for proposals and vendor selection, managing vendor contracts, and distributing annual premium. DOA promotes interagency communications, including monthly meetings of an interagency Worker’s Compensation Committee.

Internal and outside consultant auditors are employed through a claims audit committee to provide quality assurance measures to claim unit supervisors.

ROLES AND RESPONSIBILITIES WORKER'S COMPENSATION CLAIMS EXAMINER

I. Accident Report Form Processing

Review completed Accident Report forms for errors. Train and assist coordinators in making correct calculations based on DWD rules.

UW, DOT: Calculate wages and complete DWD forms

II. Investigations

Obtain factual information to determine the State's liability.

Order independent investigations and surveillance.

Place special emphasis on independent investigations of carpal tunnel and stress claims.

III. Medical Records

Receive medical records and bills from coordinators. Evaluate medical records and approve payment of bills. Forward bills to medical bill audit vendor for review and payment.

NOTE: DOT claims examiners initiate their own medical record requests.

IV. Compensability

Analyze claim to determine compensability (e.g., did the injury arise out of employment; is the injury claimed related to the work accident; does the injury meet legal definitions of "injury"?).

Accept or deny the claim.

Notify claimant, agency, providers and DWD of any denials and provide appeal procedures.

V. Disbursements

Make all payments for wage compensation, medical bills not covered by the bill auditing firm, and other claims costs.

Calculate Permanent Partial Disability (PPD) payments.

VII. Medical Management

Evaluate the need for Independent Medical Exams (IMEs) and prepare a request for each exam, including pertinent questions and information.

Evaluate the need for Telephonic Case Management and medical records review and prepare a request for each review, including pertinent questions and information.

Notify and serve all parties with IME or record review results.

Initiate disputes over necessity or reasonableness of treatment. Private firms are used to evaluate treatment and intervene to negotiate alternative treatment where appropriate. The claims examiner is the principal client of these firms. The claims examiner refers cases to the firms and works with specialists in determining the best course of action. Final decisions on treatment recommendations or disputes rest with the claims examiner.

Make referrals to private rehabilitation nursing vendors for medical case management assistance on cases requiring site assistance.

VIII. Vocational Rehabilitation

Evaluate the need for vocational rehabilitation and refer claimants to the Reemployment Specialist.

Monitor vocational rehabilitation progress and work with the Reemployment Specialist in managing vocational cases..

IX. Subrogation

Identify subrogation opportunities and notify claimants of subrogation procedures.

Negotiate subrogation settlements.

Approve third party distributions.

NOTE: All subrogation activities should be coordinated with the Claims Supervisor and Department of Justice.

X. Hazardous Duty (Section 230.36)

Certain classes of injured employees may qualify for Sec. 230.36 Hazardous Duty payments if injured in the line of duty. The employee files a standard worker's compensation claim, but also files a "Request for Leave of Absence With Pay Due To Injury," Form DER-DCC 22. The claims examiner determines liability and refers the decision to the coordinator. (Normally, the agency officer making the 230.36 decision will accept the claims examiner's recommendation).

(DOT and UW claims examiners also determine 230.36 liability and process 230.36 wage claims).

XI. Training and Information

Train agency coordinators and make presentations on worker's compensation to other agency personnel and claimants. Respond to inquiries by claimants about the worker's compensation process and issues pertaining to their claims. (Generally, agency coordinators maintain contact with claimants. However, the claims examiner responds to specific questions about the claim and becomes involved in working with claimants on a variety of matters).

XII. Worker's Compensation Act and Rules

Interpret law and rules for agency personnel and assure compliance.

Respond to DWD inquiries.

Work with DWD personnel, including Administrative Law Judges (ALJs), to resolve problems or disputes.

XIII. Hearings

Prepare for DWD hearings over disputed claims, including preparation of claims files, answers to hearing applications and compliance with time requirements for filing information with DWD.

Represent agencies at pre-hearings and work with DOJ attorneys on hearing representation.

Comply with DWD Hearing Orders (or orders coming down from appeals.)

XIV. Reserves

Set case reserves on all claims and work with Claims Supervisor in handling reserves for claims above the Examiner's level of authority.

XV. Settlements

Negotiate settlements (compromises) with claimants and/or their attorneys.

Assure timely and appropriate compliance with DWD compromise orders.

XVI. Three Point Contact

Make three point contacts with claimants, supervisors and physicians. The "three point contact" is a common method insurers use to assure rapid and effective information gathering for case management and direction.

State claims examiners have the advantage of worker's compensation coordinators who can gather a great deal of information to assist with claims management. However, the degree of knowledge, sophistication and availability of coordinators varies among agencies. Smaller agencies need more direct and active involvement in all stages of claims management.

Information gathering can be modified to the degree the coordinator has obtained certain types of needed information. The claims examiner needs to communicate regularly with the coordinator to maintain awareness of each claim's status.

Only lost time claims will be subject to the three point contact. A model procedure is attached.

ROLES AND RESPONSIBILITIES

WORKER'S COMPENSATION COORDINATOR

I. Organizational Status

DOT: Payroll officer in each division.

UW System: Campus personnel office or safety office employee. Some claims examiner-type functions at UW-Madison and UW-Hospital & Clinics.

DOA: Personnel, benefits & payroll unit employee in each department or institution. Positions vary, from Personnel Director to Payroll Clerk. Some agencies assign more than one person to coordinator responsibility. Most agencies have formally identified coordinators who report accident information directly to DOA. Some agencies with outlying offices have individuals at those offices responsible for performing coordinator duties.

Support varies among agencies. In some cases, the coordinator is part of a team of risk management, safety and worker's compensation. In some institutions, occupational health nurses are part of the team.

Section 230.36 Hazardous Duty Pay responsibilities vary. Most coordinators participate in 230.36 determinations, but another official determines 230.36 eligibility.

II. Roles and Responsibilities

1. Obtain initial injury report (incident report) from injured worker's supervisor. Assure the injury report is complete.
2. Obtain *Employer's First Report of Injury or Disease* (DWD WKC-12), *Employee Occupational Accident and Injury Report* (DOA 6058), and *Supervisor's Accident Analysis and Prevention Report* (DOA 6437) from the injured worker's supervisor. Obtain *Safety Coordinator's Review* and any supplemental forms from the Safety Coordinator, complete employee funding and coding (DOA 6733)¹. Assure all reports are complete.
3. Forward all forms to the Claims Examiner as soon as they are received.

¹ Beginning in 2001, many agencies are using the Bureau's new Risk Management Information System, STARS, and STARSWeb, to electronically produce and send forms to DOA

4. Provide the injured employee with benefits information (medical payments, disability income benefits) and other Worker's Compensation Program information. Maintain regular contact with the employee during the course of the claim.
5. Process internal forms necessary for benefits management. Perform wage and disability income rate calculations.
6. Coordinate involvement of supervisors, risk manager and safety officer on each worker's compensation claim, assuring the accident or disease is well documented, the injured employee is assisted and supported, risk and safety factors are responded to appropriately, and all documentation is provided to the coordinator.
7. Serve as liaison between the agency and the claims examiner. Keep the claims examiner apprised of any problems with the claim, investigate the circumstances of each claim and, on request of the claims examiner, conduct specific investigations and assist with internal and formal investigations.
8. Maintain agency records on each claim and on agency worker's compensation costs, injury statistics and other relevant data. Provide data to agency management, informing managers of individual and summary claims and accident status and data.
9. Assure OSHA 200 logs are completed and maintained.
10. Coordinate agency return to work (RTW) efforts by contacting the employee's supervisor/unit to assure readiness for any necessary accommodations and to identify suitable transitional work, obtaining return to work approvals from the treating physician and notifying the employee to return to work.
11. Obtain and review medical bills and notes to identify any irregularities, such as treatment not related to the work injury. Correspond with the physician to clarify any billing matters.
12. Calculate, or provide information to payroll to calculate, accrued paid leave restoration and retirement credit.
13. Respond to DWD informational requests, copying the claims examiner, or forwarding DWD requests to the claims examiner for handling.

WORKER'S COMPENSATION CLAIMS PROCESS

Introduction

The “ideal claims process,” was developed by a worker’s compensation project team to chart those steps recommended for each agency and campus in managing their worker’s compensation claims. The keys to the process are:

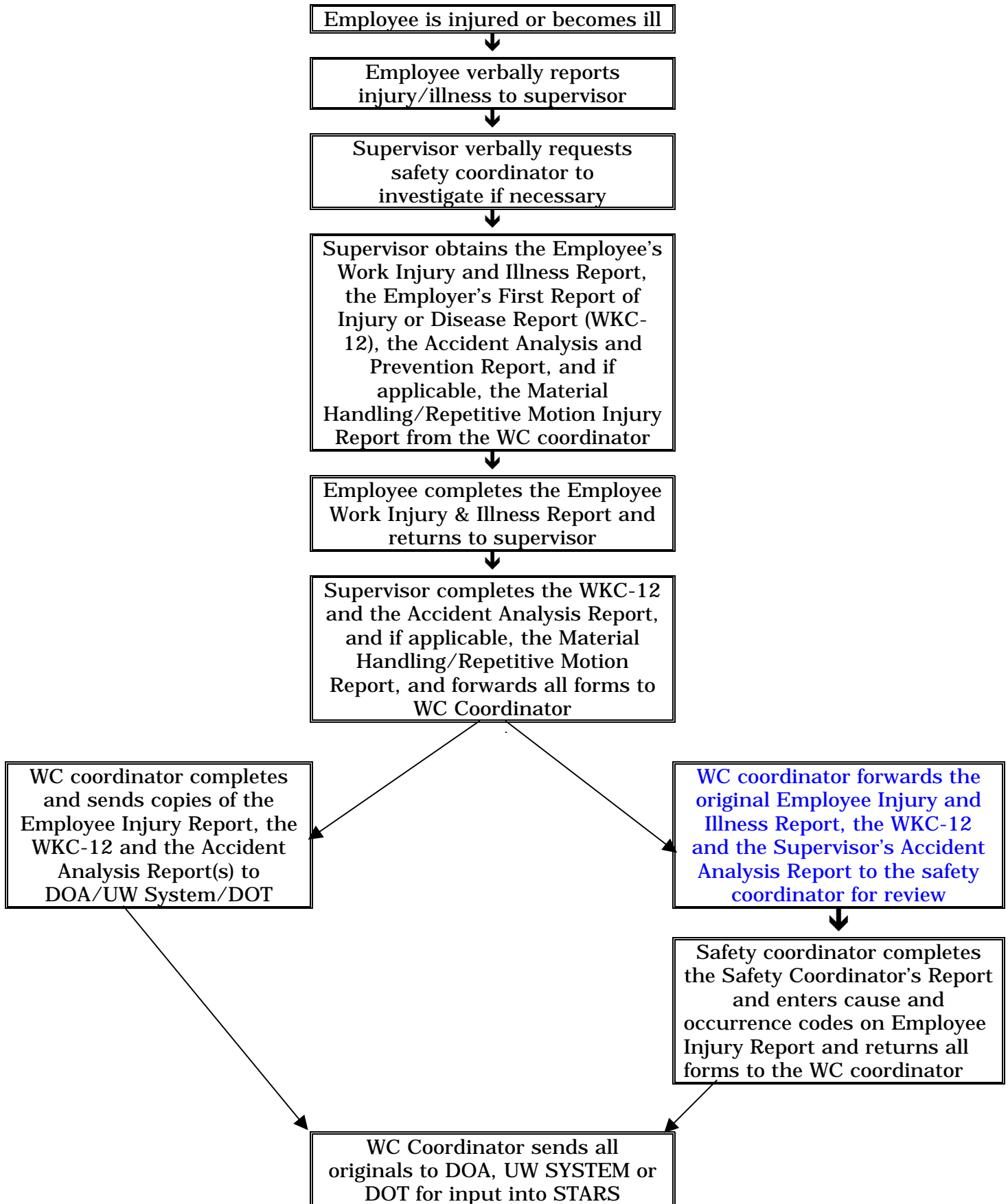
1. Immediate reporting of all accidents.
2. Timely investigations and documentation by supervisors and safety coordinators.
3. Assuring all reported information is immediately sent to the claims examiner so that steps can be quickly taken to gain control of the claim.

It has been repeatedly proven that reporting claims promptly will substantially reduce the average claims costs.

The contents of the Manual have been excerpted from several sources. It is recommended that each Coordinator and Supervisor obtain a copy of “Principles of Accident Analysis,” published by the Department of Administration, Bureau of State Risk Management and available from the Bureau’s Loss Control/Safety Manager. The Bureau also has video training on accident analysis and can refer inquiries to future training sessions on this topic.

The Department of Natural Resources “Worker’s Compensation” excerpt from the “Health, Safety & Risk Management Reference,” is an excellent example of the proper steps and roles of the employee, supervisor, and coordinators and may be useful to any agency in outlining its internal worker’s compensation procedures. DNR uses several coordinators because of its statewide offices. Other agencies may want to adjust those duties depending on their geographic office distribution.

APPENDIX F - WORKER'S COMPENSATION CLAIMS REPORTING PROCESS



APPENDIX G

DEFINITIONS OF TERMS ASSOCIATED WITH ACCIDENT ANALYSIS

- ***Accident*** - An unplanned, undesired event that may result in personal injury, illness, property damage, and environmental harm and/or causes an interruption in a process or normal activities.
- ***Accident Analysis*** - The investigation and analysis and written account of a near miss, incident or an injury or illness based on information gathered by a thorough examination of all factors involved. An accident analysis includes the objective evaluation of all facts, opinions, physical evidence and statements taken from the affected employee and witnesses. A thorough accident analysis will also identify the primary and secondary causes of the accident and possible deficiencies in the management system so that corrective action(s) can be determined and taken to prevent recurrence.
- ***Change Analysis*** - A process used to determine the causes of an accident by comparing the way a job was actually performed with the way it should have been performed.
- ***Causal Factor*** - An event, person, hazardous condition or unsafe act that contributed directly or indirectly to an accident.
- ***Fault Tree Analysis*** - A method of analysis which reasons backwards from an undesired occurrence to determine possible causes. Fault tree analysis is most useful for organizing the analysis of complex situations where many possible causes exist.
- ***First Aid*** - Any one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care. Such treatment and observation are considered first aid even though provided by a physician or registered nurse.
- ***Hazardous Condition*** - Any condition that may result in, or contribute to, an accident.
- ***Hazard Control*** - A means of reducing the risk due to exposure to a hazard. Such means may include: ergonomic design of work stations, and equipment; arrangement and guarding of machinery; barricading of pedestrian and vehicular traffic routes; process controls to limit exposure to toxic materials; ventilation and exhaust systems; prescribed work practices including the wearing of personal protective equipment; and visible and/or audible warning devices.

- ***Incident*** - An unplanned, undesired event that did not immediately result in an injury or illness but may result in an injury or illness at some point in the future.
- ***Investigation*** - A systematic search to determine how and why an accident, incident or near miss occurred.
- ***Material Handling Injury*** - An injury that involves the lifting, handling and/or moving of an object or person.
- ***Medical Treatment*** - Treatment of injuries and illness administered by physicians, registered professional personnel, or lay persons. Medical treatment does not include first aid treatment (one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters and so forth, which do not ordinarily require medical care) even though provided by a physician or registered professional personnel.
- ***Near Miss*** - An unplanned, undesired event that nearly resulted in a personal injury/illness or property damage.
- ***Occupational Illness*** - Any acute or chronic condition or disorder caused by exposure to environmental factors associated with employment. They include conditions or diseases that are caused by inhalation, absorption, ingestion or direct contact with toxic materials such as hazardous chemicals, silica dust asbestos, etc.. Occupational illnesses also include disorders associated with repeated trauma or motion such as carpal tunnel syndrome.
- ***Occupational Injury*** - Any injury such as a cut, fracture, sprain, amputation, etc., which results from a work accident or from a single instantaneous exposure in the work environment.
- ***OSHA Lost Workday Case*** - A work-related injury or illness causing an employee to be unable to perform any available work for one or more workdays.
- ***OSHA Restricted Workday Case*** - A work-related injury or illness that causes an employee to be unable to perform his or her regular job without restriction.
- ***OSHA Recordable Cases*** - All work-related deaths and illnesses and work-related injuries that results in loss of consciousness, restriction of work or motion, transfer to another job, or requires medical treatment beyond first aid.
- ***Repetitive Motion Injury*** - An injury that is caused by the repetitive use of the wrists, hands, arms, shoulders and/or neck.

- ***Unsafe Act*** - A behavioral departure from an accepted, normal, safe, or correct procedure or practice which, in the past, has produced injury, illness or property damage or which has the potential for doing so in the future.
- ***Witness*** - An individual who personally observes the occurrence of a particular event or who is familiar with the circumstances involved in the incident.
- ***Work Environment*** - Consists of the employer's premises and other locations where employees are engaged in work-related activities or are present as a condition of their employment. The work environment includes not only physical location, but also the equipment or materials used by the employee during the course of work.

WORKER'S COMPENSATION FRAUD

I. SCOPE OF FRAUD.

A. A Survey Reveals that Attitudes Promote Fraud. A Survey performed by the National Council on Compensation Insurance revealed the following:

- I. Twenty-five percent of those polled said they knew of people who had stayed home after they were able to return to work and had continued to collect worker's compensation. The more aware respondents were of this practice, the more likely they were to condone it.
2. Seventeen percent of those surveyed said it was acceptable for someone to remain home after they were able to return to work from worker's compensation.
3. Eight percent thought it was acceptable for a person to claim that a nonwork-related injury occurred on the job in order to collect worker's compensation benefits.
4. Ten percent said it was acceptable to be out of work for a month because of stress and to claim the stress was work-related even if it was not.
5. Six percent condoned an employee's practice of staying home even after the employer had made special accommodations for that employee's disability.

B. Costs of Fraud.

- I. Employers nationwide paid an estimated \$60 billion to support worker's compensation programs in 1991.
2. Losses to insurance companies from worker's compensation claims totaled \$1.7 billion in 1991.
3. The incidence of worker's compensation fraud has increased exponentially, as has insurance fraud generally.
4. The Insurance Information Institute estimates that 20 percent of all worker's compensation claims are fraudulent.
5. Vendor fraud and abuse by highly organized business created to generate phony legal and medical fees now accounts for \$1 billion in fraudulent and abusive claims in California alone.
6. The cost of an average worker's compensation claim in 1990 was \$19,444, more than three times the \$6,138 it was in 1980.
7. Of that \$19,444, \$6.611 represented medical expenses, up 278 percent from the \$1,748 average in 1950.
8. Since 1980 worker's compensation costs have grown at more than 12 percent a year; 15 to 20 percent annually in some states.
9. Despite advances in medical care, the amount of time missed from work grew about one-third in the same period and in 1989 totaled 60 million workdays lost due to job-related injuries.
10. In 1991, each worker's compensation claim cost an average of \$363 a week and lasted nearly three weeks; the average premium per worker increased from \$93 in 1972 to \$500 20 years later .

*Reprinted from a presentation by Attorney Charles B. Palmer
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(414) 798-1111 at the State Risk Management and Safety Congress
on November 13, 1996.*

II. CRIMINAL STATUTES

A. **Wisconsin Statute 943.395** -Fraudulent insurance and employee benefit program claims.

1. Whoever, **knowing** it to be false or fraudulent, does any of the following may be penalized as provided in sub. (2):
 - a. Presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; or
 - b. Prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, **with knowledge** that the same may be presented or used in support of a claim for payment under a policy of insurance.
2. Whoever violates this section:
 - a. Is guilty of a Class A misdemeanor if the value of the claim or benefit does not exceed \$1,000.
 - b. Is guilty of a Class E **felony** if the value of the claim or benefit exceeds \$1,000.
3. Penalty
 - a. Class A misdemeanor = a fine of not to exceed \$10,000 or imprisonment not to exceed 9 months, or both.
 - b. Class E felony = a fine not to exceed \$10,000 or imprisonment not to exceed 2 years, or both.
4. Criminal Intent Required

Wisconsin Statute 939.23 -Criminal Intent

When criminal intent is an element of a crime in chs. 939-951, such intent is indicated by the term "intentionally," the phrase "with intent to," the phrase "with intent that," or some form of the verbs "know" or "believe."

B. **Federal Criminal Actions.**

Racketeer Influenced and Corrupt Organizations (RICO):

Mail Fraud -mailing by an insured to an insurer of a false insurance claim constitutes a violation of the mail fraud statute and thus is a violation of the requirements of RICO. (Provides for up to \$1000 fine and/or 5 years in prison.)

III. **PROSECUTION OF WORKER'S COMPENSATION FRAUD.**

A. **Department of Workforce Development Responsibility.**

Under Wis. Stats. § 102.125, if an insurer or self-insured employer has evidence that a claim is false or fraudulent in violation of §943.395 and if the insurer or self-insured employer is satisfied that reporting the claim to the department will not impede its ability to defend the claim, the insurer or self-insured employer shall report the claim to the department. The Worker's Compensation Division

will review the allegations and may refer the results to the appropriate district attorney for prosecution if there is reasonable basis to believe fraud occurred.

B. Employer Responsibility

The Worker's Compensation Division acts as a clearinghouse for claims of fraud and has no resources to perform a thorough investigation of the claim. The employer and/or its insurance carrier must provide complete and detailed documentation to the Division so that the evidence of fraud is clear and easily understood.

C. Standard of Proof

Because criminal prosecution requires proof of guilt beyond a reasonable doubt, only claims in which there is clear evidence of misrepresentation and intent to obtain worker's compensation benefits through that misrepresentation, will be accepted for prosecution.

D. Fraud Hotline.

The Worker's Compensation Division has established a fraud hotline to report fraudulent claims. The employer and insurance carrier should work together to prepare evidence of worker's compensation fraud and contact the Worker's Compensation Division at:

**Worker's Compensation Division
Department of Workforce Development
201 E. Washington Ave
P.O. Box 7901
Madison, WI 53707-7901**

Fraud Hotline: (608) 261-8486

IV. EMPLOYER FRAUD PREVENTION TECHNIQUES.

A. Generally. In addition to criminal prosecution; injury prevention, investigation, communication, and discipline are the key elements to a successful fraud prevention program.

B. Injury Prevention.

1. Preventing injuries is the best method for avoiding abusive claims and manipulation of the employer's worker's compensation program, because an injury must occur before worker's compensation benefits can be paid.
2. While prevention programs may not eliminate claims which are entirely fabricated (i.e. no injury occurred), preventive measures avoid the fraudulent claims that may arise where an employee, who is legitimately injured, attempts to manipulate his/her claim in order to enhance benefits, due to anger that the employer allowed the injury to occur, or fear that worker's compensation may not provide enough compensation for loss of job opportunity caused by the injury .
3. Preventive measures establishing safety rules and discipline for violation, provide disincentives to false claims of injury , due to fear of discipline.

4. Where an injury does occur, prevention techniques should also include minimizing the extent of the claim's impact, by assuring immediate and quality medical care, and prompt payment for that care, as well as return of the employee to gainful employment as soon as possible.
5. Prompt payment and return to work, reduces the costs of the injury to the employee, and the uncertainty that arises from being out of work and receiving notices of increasing unpaid bills.
6. These measures also assist the employer in identifying potential suspicious claims, where the employee is overly resistant to seeking medical care or allowing the employer to work with his/her health care provider, or resists employer efforts to return the employee to available work that fits the employee's restrictions.

C. Investigation.

Thorough investigation and follow-up communicates to honest employees that the employer cares about them and wishes to prevent further injury , and communicates to those who are tempted to engage in fraud that it will not be as simple as filing a claim, and that they will need to develop a consistent and substantiated story of the injury occurrence and that they will need to constantly need to look over their shoulder if they are not being honest about the claim. The front line defense against fraudulent claims is thorough investigation of every injury , so that employees are aware that the employer:

1. Investigates injury claims immediately to verify accuracy of employee's statements and interview witnesses.
2. Questions employee regarding cause of alleged injury and assesses credibility and demeanor immediately after incident.
3. Requires employee to walk through injury event with other witnesses present to explain its occurrence.
4. Requires employee to complete and sign Employer's Accident Report. (See Appendix B).
5. Follows up to verify statements of employee and witnesses and consistency with insurance carrier reports and health care reports.
6. Requires regular contact to evaluate employee status and any changes in employee's condition.
7. Hires private investigators where a claim is suspicious and responds quickly and severely to misrepresentation.

D. Communicate to Employees What is Unacceptable.

1. The employer should communicate to its employees that it takes worker's compensation fraud seriously. A notice and poster regarding worker's compensation fraud, has also been issued by the Worker's Compensation Division and is available by contacting the Division at (608) 266-1340.
2. Inform employees that fraud includes:

- a. claiming a non-work related injury under worker's compensation;
- b. claiming to have suffered an injury that did not occur;
- c. remaining absent on worker's compensation longer than necessary;
and/or
- d. misrepresentation to the doctor, the insurance carrier, or the employer as to the nature or extent of an injury to secure greater benefits or time off.

E. Discipline.

1. Most cases of abuse in the worker's compensation system are not prosecutable as criminal fraud.
2. In order to combat fraud, employers must establish their own rules and punishment for misrepresenting a claim to obtain worker's compensation benefits.
3. These rules should include the actions which the employer considers to be fraud such as those set forth above.
4. Employees should be informed in writing of the consequences of violating the rules through an employee handbook, labor contract or other notice.
5. Where there is clear evidence of violation of the employer rules or other worker's compensation fraud, the employer should immediately investigate to determine what discipline is appropriate.
6. Often there is a tendency in worker's compensation to wait to present evidence of fraud until a hearing on the claim is held in the Worker's Compensation Division. Hearings are often long after the evidence of fraud becomes available, and such delay may undermine the employers decision to discipline or terminate the employee, as well as the ability to prosecute a fraud claim. If the employer and insurance administrator continue worker's compensation benefits and do not discipline the employee for misrepresentation, this will give rise to doubt as to whether they truly believed that the employee misrepresented the claim.
7. If the employer is convinced that misrepresentation on the part of the employee has occurred, the employee should be questioned about the events by the employer to establish the employee's explanation, or to establish that misrepresentation has occurred. Employers should contact competent legal counsel before taking such action to address the appropriate strategy and discipline.
8. Where an employee is disciplined for misrepresentation, the employer should make this known to its other employees in order to deter similar acts. However, because of the potential for legal liability , competent legal counsel should be contacted to develop appropriate communications.

V. THE DUTY TO REHIRE UNDER WORKER'S COMPENSATION:

A. Generally

Under Wis. Stats. § 102.35(3) an employer is prohibited from wrongfully refusing to rehire an employee after a worker's compensation injury .

Wisconsin Worker's Compensation Statute § 102.35 (3) provides:
Any employer who without reasonable cause refuses to rehire
an employee who is injured in the course of employment, where
suitable employment is available within the employee's physical
and mental limitations, ...has exclusive liability to pay the
employee the wages lost during the period of such refusal, not
exceeding one year's wages. ..

B. Unreasonable Termination.

This statute has been interpreted to prohibit unreasonable termination as well as unreasonable refusal to rehire following a work-related injury .The statute does not require that a person be returned to the same or equivalent position following absence due to a work-related condition. It merely requires return to suitable employment if it is available. However, the ADA may require a leave of absence or restructuring of the job as a reasonable accommodation for an individual with a disability, and the federal FMLA requires job protected leave for up to 12 weeks for a serious health condition. Both of these statutes may apply to a worker's compensation case.

C. Benefit Continuation and Reinstatement Not Required

The worker's compensation statute also does not require continued health insurance coverage while an employee is absent due to a work-related injury . However, the FMLA does require benefit continuation while an employee is absent for up to 12 weeks due to a serious health condition. This may apply to worker's compensation claimants.

D. Discipline fairly

The seven questions in order to discipline:

In union and non-union workplaces, the employer should provide employees due process before discipline or discharge. Ask yourself these questions:

1. Did the employee know the rule and the consequences?
2. Is the rule reasonable?
3. Did the employee disobey the rule?
4. Was a fair investigation conducted?
5. Is there proof that the employee is guilty?
6. Has the rule been consistently applied?
7. Does the penalty match the offense?

INDEPENDENT MEDICAL EXAMINATIONS (IME's)

Employer's Right to an IME

The State has the right, under Section 102.13, Wis. Stats. to have the injured employee examined by a physician of the State's choice. Wisconsin practice is for IMEs to be allowed only one time unless a significant amount of time has passed, or medical factors have changed greatly since the initial IME. In those cases, it is generally recommended that the additional IME be performed by the same physician that performed the first one.

IME Coordination

The claims examiner at DOA, DOT or UW System orders IMEs. Individual agencies should be careful not to order their own IMEs for other purposes (e.g., a 230.36 determination) without coordinating with the Claims Examiner. Coordination will enable a combined effort to make the best use of the IME and avoid the confusion and problems created when several parties are petitioning the same employee for an IME. Please read "Duration of 230.36 Hazardous Duty Payments to Injured Employees Under Article XIII, Section 16 of the WSEU Contract," in Chapter 11.

When to Order an IME

Ordering an IME should be a carefully considered and reasoned determination. As noted above, IMEs are allowed only once unless there are unusual circumstances. IMEs are also expensive and time consuming. They create inconvenience for the injured employee and are time consuming for the claims staff. On the other hand, they can be a very valuable tool and should be welcomed by the employee because they offer a second opinion for the employee's use.

IMEs should be considered under the following circumstances:

1. The employee has been under treatment for a lengthy period of time without apparent improvement.
2. There is a need to establish a benchmark to compare with the treating physician's statements.
3. There is a strong suspicion the employee's physical or mental capabilities are greater than the employee or the treating physician assert.
4. The employee's claim has been denied on the basis of insufficient or inappropriate medical information and he/she has filed for a hearing with the Department of Workforce Development (DWD).

There are many other circumstances when an IME may be appropriate. The claims examiner should consult with the claims supervisor for further determinations.

Selecting an IME Physician

IME physicians should be board certified in the specialty area for which the IME conditions are being evaluated. In rare cases, more than one IME physician may participate in the IME (e.g., where both a physical and a mental condition are being examined).

Several vendors are available to provide IME physicians, or a physician may be directly contacted. Do not rely on the vendor to make the final IME selection. The claims examiner should obtain curriculum vitae and other relevant information to make an appropriate choice. The state or local medical society can be a good resource for identifying specialists. DOA has a listing of available physicians. One of the vendors providing medical case management may be another good source for identifying physicians or evaluating whether a physician will provide an adequate examination.

DOA keeps a listing of IMEs, with a rating of the IME physician and comments about the physician's strengths and weaknesses.

Arranging an IME Appointment

1. Call the physician or vendor to arrange a date; there is normally a wait of at least 30 days to get an appointment.
2. Copy the medical file and send it to the vendor or IME physician. Include the WC-13, the employee's and employer's first reports of injury, and any other relevant information. (The vendor will notify the claims examiner of the deadline for submission of material).
3. Call providers and follow up in writing with requests for x-rays, MRI's, CT scans, etc. be sent directly to the IME vendor or physician. There must be a request in writing for these items.
4. Section 102.13, Wis. Stats. requires providers to release "...any information or written material reasonably related to any injury for which the employee claims compensation." However, experience is that providers will often not comply without a specific release signed by the employee.
5. Write the employee and include the following required information:
 - a. Date, time and place of the exam;
 - b. Physician's name and area of specialty;
 - c. Instructions on how to request a change in the date and time of the exam;

- d. The employee's right to have his/her physician present at the time of the exam (at the employee's expense); and
 - e. The employee's right to receive a copy of the IME report.
6. If the employee is represented, send the letter directly to the employee's attorney.
 7. Send a copy of the letter to the worker's compensation coordinator; follow up with a telephone call to provide relevant information to the worker's compensation coordinator.
 8. Advance an estimated travel allowance to the employee before the exam date. If the exam requires wage loss, that amount must also be advanced.

Missing IME Appointments

If the employee misses the IME without timely notifying the claims examiner or the worker's compensation coordinator, the State will be charged a fee. Benefits may not be terminated without approval of a DWD administrative law judge. Further benefits may be suspended and a denial letter sent if there is no medical excuse for missing the appointment.

The IME Letter

The content of the IME letter is extremely important. The letter should be specific about what information is requested and written in a manner to prevent the physician from adding information not requested. Consult the claims supervisor and the dispute resolution manager for preferred formats, questions, and legal language.

The IME Report

The IME report should be received about 2 weeks after the examination. It should be reviewed for accuracy and completeness (all questions answered). It should be evaluated for credibility. If the letter is not satisfactory² contact the vendor or IME physician immediately and request a revision or supplement. There should be no charge if the error is the fault of the vendor/physician.

Write the employee and send a copy of the report. Outline the salient points and explain any impact on future benefits. DWD must be notified of a suspension or denial of benefits, including the following:

1. Copy of IME Report
2. WC-13 "Supplementary Report on Accidents and Industrial Diseases" clearly marked "suspended" or "denied" and "see attached IME"

² Objective, accurate and reasonable letters are preferred. We do not expect the IME physician to stretch an opinion to meet a perceived need to deny a claim.

Notify providers if medical benefits are suspended or denied. Determine whether to request reimbursement of prior paid expenses. If requesting repayment for an extremely large amount, significant payment overcharges, or if a long period of time has elapsed since payment was made, discuss this with the claims supervisor or dispute resolution manager. In many cases, the amount to be recouped may be taken into account in a settlement. The determination of when to discontinue benefits, and the appropriate date for discontinuance, should be handled on a case by case basis.

SUBROGATION

Definition

Worker's compensation subrogation is a process where the State "subrogates," or asserts its rights as a creditor in a third party lawsuit. The State's claim is based on past and future benefits to be paid to the injured employee. The claim is against a portion of proceeds from the lawsuit.

The subrogation procedure is provided in Section 102.29, Wis. Stats. The "third party" is usually a manufacturer of faulty products or an individual causing damage to the employee through their negligence, resulting in the worker's compensation claim. Examples might be a poorly manufactured ladder or an automobile accident. The employee brings the suit with the aid of a private attorney.

Distribution of Proceeds

Once the lawsuit is tried, or settled, Section 102.29 (1) provides for distribution of the proceeds as follows:

1. Attorney's fees
2. One-third of the remainder to the employee
3. Two-thirds of the remainder to the insurer (state)

The State is only entitled to an amount equal to benefits paid out; if that amount is less than the 2/3 share, the rest goes to the employee in addition to the employee's 1/3 share. However, the State is entitled to a "cushion," where the extra amount that went to the employee is considered a credit for the State against future worker's compensation benefits.

Managing Subrogation

Subrogation is an opportunity for the State to recover significant amounts of benefit costs. However, for subrogation to be effective, successful lawsuits must be pursued. The agency and the claims examiner can work together in such efforts.

Immediately upon notice that an accident has occurred, the agency safety officer should analyze the accident scene. Any equipment or material contributing to the accident should be secured. Photographs should be taken of the scene and any contributing elements. The worker's compensation coordinator and the claims examiner should be notified.

The claims examiner should direct the subrogation aspects of the case. The claims examiner should gather the relevant information from the agency safety officer and worker's compensation coordinator. The information should be evaluated and the employee contacted with a recommendation to obtain an attorney and pursue possible action.

Subrogation Procedures

The following steps should be taken by the claims examiner:

1. Determine whether third party subrogation is appropriate. This step usually occurs during an analysis of accident reports or through a contact with the worker's compensation coordinator. Any catastrophic injury, fatality, or automobile accident should constitute a "red flag" and be investigated for potential tort action.
2. Contact the worker's compensation coordinator and gather as much information as possible. Ascertain whether an accident analysis was completed; whether evidence was secured, how and where; and whether photographs and statements were taken.
3. Contact the employee and determine if there is interest in pursuing a lawsuit and whether an attorney has been secured. Obtain the name, address, and phone number of the attorney.
4. Identify the third party defendant and their insurance companies, including names, addresses and phone numbers.
5. Call the state employee's attorney and the third party insurer, indicating knowledge of the litigation and advising each of the state's subrogation rights. Notify the Department of Justice, subrogation unit.
6. Obtain an accounting of all benefits paid out on the claim.
7. Write the employee's attorney and the third party insurer indicating that the State must be kept informed of any final settlement, and that the State requires the original copy of the signed settlement form in order to provide approval of the settlement.
8. The Department of Workforce Development (DWD) must sign-off on the settlement form to authorize the subrogation and the settlement.

Subrogation Potential Checklist

--Product Liability

- Attempt to identify the product by brand name, model, serial number, and name and address of manufacturer and its liability insurer.
- Suggest that the employee locate and save all materials concerning the product such as receipts, instructions, etc.
- Try to determine if the employee was using the product properly at the time of the injury.
- Suggest that the employee retain the product in its present condition.
- Determine whether there have been prior problems with the product. If it was repaired, determine when and obtain the name and address of the party making the repair and its liability insurer.
- Suggest that the employee locate and save all materials concerning the repair of the product.
- Determine whether the product was altered by the employee, the employer or a co-worker.
- Attempt to get statements from the employee and witnesses.

--Faulty Repairs

- Review product liability questions above as applicable. In addition,...
- Determine why repairs were needed.
- Determine what repairs were made, when they were made, and by whom.
- Attempt to get statements from the employee and witnesses.

--Automobile or vehicular accidents

- Determine the identity of the driver, owner and insurer of all vehicles involved.
- Determine whether the other drivers were within the scope of their employment, i.e., what were the purposes of the other drivers' trips.
- Get a copy of any police reports and accident reports regarding the accident as well as any photos taken of the accident scene.
- Attempt to get statements from the employee and witnesses.

--Accident which occurred on another party's premises such as a slip and fall

- Determine the name and address of the owner of the premises and its liability insurer.
- If the property is leased, determine the name and address of the lessee and its liability insurer.
- Determine whether any third party was responsible for maintenance of the premises and if so, determine its name and address and the name and address of its liability insurer.
- If an individual was apparently responsible for the injury, identify the individual and his/her relationship to the owner, lessee or maintenance company.
- Attempt to get statements from the employee and witnesses.

-Intentional tort such as an assault.

- Obtain the name and address of the assailant and the name and address of his or her liability insurance company. Usually this will be a renter's or homeowner's policy. While these policies generally contain exclusions for intentional acts, there are times when the insurer will pay all or part of a claim where the conduct could be considered intentional.
- Obtain the names and addresses of any persons who were with the assailant and the names and addresses of their liability insurance companies.

- If the assault occurred on privately owned premises, determine whether similar assaults had occurred there in the past.
- Obtain the name and address of the owner and, if applicable, the lessee of the premises and their liability insurance companies.
- Obtain copies of all police reports and of any photos taken concerning the incident. Often there will be photos of the injured party showing the extent of the injuries.
- Attempt to get statements from the employee and witnesses.
- Contact the Crime Victim Compensation Program at the Department of Justice to coordinate payments and subrogation information. Generally Crime Victim Compensation will not pay benefits for items covered by WC.

Regulatory Provisions

THREE - POINT CONTACT

Contact with the injured employee, employer and doctor (or representative, e.g., nurse) must be made within 24 hours of receipt of the claim. All contacts must be properly documented and reasonable efforts must be made to document the contacts, such as leaving messages and follow-up if no response to your message in 24 hours.

INJURED EMPLOYEE CONTACT:

1. Clarify the description of the injury if the Employee Report does not contain enough information to explain how the injury occurred and if the injury was sustained on the job and in the course of employment.
2. Clarify what body part(s) was injured.
3. Clarify the injury date - the claim must be filed within two years after the date of injury. If the exact date of injury cannot be determined, the date of injury must be the first date that a reasonable person knew or should have known that the injury was a result of employment. At times, the date the injured employee first sought treatment could be the date of injury. Request the injured employee to follow up in writing documenting the exact date of injury. If necessary, a letter should be sent to the doctor clarifying if/when the doctor told the injured employee his/her condition was a result of his/her work duties.
4. Clarify the date and time the injured employee left work.
5. Clarify the injury location - whether the injured employee was on the employer's premises and/or in the course of employment.
6. Clarify prior problems and prior claims.
7. Clarify the name of the attending physician. The medical provider field in the WCCS screen must be updated to reflect this information.

Physician's assistants, nurse practitioners, industrial/occupational nurses, physical therapists, and massage therapists are not considered as attending doctors. The injured employee should be contacted to see if he/she was physically examined by a doctor. If the physician's assistant, nurse practitioner, industrial/occupational nurse, physical therapist, or massage therapist treat the employee after the initial evaluation, none of the above are acceptable for verifying disability or prescribing medication.

Identify the date the injured employee was first treated. If there was a

delay in treatment and the injured employee is requesting disability benefits since the date of the injury, question the injured employee. If the injury was such that he/she could not perform work duties, why was there a delay in seeking medical treatment?

8. Date of next medical appointment.
9. Date of return to work. Determine if return was full time, part time, and for what hours and days, and at what wages.
10. Determine and document restrictions placed on the injured employee.
11. Identify witnesses to the injury and their addresses.
12. Determine if the injured employee has a second job, if he/she is able to perform the duties associated with the second job, the name of the employer, the wages paid, the work schedule, the date of return to work , and if the employee cannot return to the second job, whether the second employer can provide modified work.
12. Clarify any other pertinent information on the Employee's Report which has not been completed or needs to be clarified.

EMPLOYER CONTACT:

1. Clarify the injury, the location of where the injury occurred and the date/time of the injury.
2. Ask if the employer has any concerns/protests of the claim, and if so, document any pertinent facts for further follow-up. If an incident report or other information was completed and not sent to you, please request a copy.
3. Verify the injured employee's first day off work and verify the work schedule for the first seven calendar days of disability.
4. Verify the injured employee's wages
5. Verify the injured employee's return-to-work date.
6. If the injured employee has not returned to work, inquire of the employer if modified work is available.

DOCTOR (OR REPRESENTATIVE) CONTACT:

1. Request a description of the injury given to the doctor by the injured employee.
2. Verify the first date of treatment, the treatment the doctor performed, and further recommended treatment.
3. Obtain the doctor's diagnosis of the injured employee's medical condition.
4. Ask if the injured employee has been released to return to work. If so, is there a release for full time or part time, and are there any restrictions?
5. Ask the doctor to verify if the injured employee is able to perform his/her work duties?